purpose. **METHODS:** An electronic quantitative survey was administered to 150 attendees of the 17th ISPOR European Congress in Amsterdam, Netherlands, in November 2013, using a random sampling method. The respondents included representatives from academia, industry, consulting firms, clinicians, and public/government agencies. **RESULTS:** Respondents identified the five most important attributes driving positive reimbursement as: cost-effectiveness, quality of life, clinical efficacy, budget impact, and therapeutic innovativeness. Almost all respondents (91.3%) believe ICER thresholds should be used to evaluate new health technologies (formally or informally). Approximately 75.9% believe that ICER thresholds should increase beyond the current value of £30,000/QALY. The average suggested threshold is £51,274/QALY, regardless of therapeutic area. For a disease with high clinical unmet need, respondents suggest an average threshold of £61,535/QALY. The majority of respondents believe ICER thresholds should be an integral part of HTA; however, many believe the current thresholds inadequately reflect the value of innovative therapies. Specifically, respondents expressed that the thresholds should be raised for innovative treatments in therapeutic areas lacking significant treatment alternatives, as well as novel treatments for rare diseases. Additionally, 69.0% of respondents believe that the current level of ICER thresholds limits the availability of truly innovative therapies; hence a new threshold that varies by therapeutic area and degree of clinical unmet need should be established. **CONCLUSIONS:** A majority of respondents support the use of health economic evaluation, but believe that current ICER thresholds are too low and do not accurately reflect the value of novel therapies. The average threshold suggested is £51,274/QALY. Respondents indicate that the current ICER thresholds limit patient access to truly innovative therapies.

PHP115

JAPAN PRICING METHODOLOGY ANALOGUE ASSESSMENT

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OBJECTIVES: The objective of this study was to identify recently launched molecules in Japan that were priced using the cost-plus calculation vs. cost-comparison pricing method and to evaluate the rationale behind their pricing decisions. **METHODS:** 211 molecules assessed for pricing between March 2011 and August 2014 in Japan by the Ministry of Health, Labour and Welfare (MHLW) were considered in this analysis. **RESULTS:** Of 211 molecules assessed for pricing between March 2011 and August 2014, 71 (34%) molecules had a novel mechanism of action for their respective indication, while 140 (66%) did not. Of the 71 novel mechanism of action molecules, 53 (75%) molecules underwent cost-plus pricing, while 18 (25%) underwent cost-comparison pricing. 15 of the 18 likely underwent cost-comparison pricing either due to their non-differentiated clinical efficacy or similar mechanism of action as those of existing molecules or due to the crowdedness of the space; 3 of the 18 underwent cost-comparison pricing due to their mechanisms of action being broadly defined. Of the 140 non-novel molecules, only 7 (5%) molecules were priced under cost-plus pricing despite not being first in class, as their comparators had launched 15+ years ago and were thereby deemed inappropriate for comparison purposes. **CONCLUSIONS:** The majority of novel mechanism of action molecules underwent cost-plus pricing. Nevertheless, a number of molecules with novel mechanisms of action were priced under cost-comparison pricing. Conversely, several non-novel molecules were priced under cost-plus pricing despite not being first in class. It can therefore be concluded that while the novelty of a molecule's mechanism of action serves as the main driver for determining which pricing method is used by the MHLW, it is not the only driver behind the decision.

PHP116

LITERATURE REVIEW OF THE USE OF ICER THRESHOLDS IN HEALTHCARE DECISION-MAKING

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OBJECTIVES: In several countries, incremental cost-effectiveness ratio (ICER) "thresholds" aid in the healthcare decision-making process by helping prioritize the distribution of resources across interventions. The aim of the study was to assess the use of ICER thresholds in the P&R process, and understand the evolution of ICER thresholds over time. **METHODS:** A targeted literature review was conducted using search terms to address the following research questions: (i) How have ICER thresholds changed over time to reflect advances in medical technology? (ii) What is the societal willingness to pay (WTP) per QALY? (iii) How do the ICER values of interventions treating different diseases compare? PubMed and Grey Literature were searched for relevant studies published in English between January 1970 and September 2014. **RESULTS:** This review summarizes evidence from 48 studies. Literature revealed that countries use explicit and implicit ICER thresholds during the P&R process. In the US and UK, thresholds were established in 1982 and 1999 respectively, and despite significant advances in medical technology, these have not been updated. Our review indicates that the estimated societal WTP in the US is between $109,000–$297,000/QALY, and it has been recommended that the ICER threshold be raised to at least $200,000/QALY. Additionally, our review shows that ICER values vary significantly for different therapeutic areas based on medication cost, unmet need, and severity. For example, the average ICER value for an intervention treating Non-Small Cell Lung Cancer ($100,442/QALY) is approximately four-fold that of Type 2 Diabetes ($22,663/QALY). **CONCLUSIONS:** Researchers cite that ICER thresholds are dynamic, and should change over time to account for innovation in technology, inflation and increased research and development costs. In addition to end-of-life care, efforts should be made to establish different thresholds for diseases with high unmet needs to facilitate patient access to novel therapies.

PHP117

THE TROUBLE WITH COST-UTILITY HTA BODIES: THEY SHOULD DETERMINE THE PRICE NOT REACT TO IT

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OBJECTIVES: Many key pharmaceutical markets (including England, Scotland, Canada and Australia) have Health Technology Assessment (HTA) bodies for which cost-utility analyses are key criteria. For such bodies, acceptable cost per Quality-Added Life Year (QALY) based on the manufacturer's submitted price must be demonstrated. By contrast, in other major markets (such as France and Germany), a level of added benefit is ascribed to a drug and based upon this a price is negotiated. However, the expansion of international reference pricing means that prices in major ex-US markets are increasing converging. Thus the major difference between such agencies becomes the coverage, which this research compares, using the example of 2 recent high cost breast cancer therapies. **METHODS:** Publically available HTA reports for Kadcyla and Perjeta from the pan-Canadian Oncology Review (pCODR), National Institute for Health and Care Excellence (NICE), Scottish Medicine Council (SMC), Institute for Quality and Efficiency in Healthcare (IQWiG, Germany), Haute Autorite de Sante (HAS, France), and Australian Pharmaceutical Benefits Advisory Committee (PBAC) were screened (up to December 2014) and the decision, date and key rationale were extracted. **RESULTS:** NICE, SMC, PBAC, and pCODR have all appraised both Kadcyla and Perjeta but none of these bodies have found either of these drugs to be cost-effective. By contrast, HAS and IQWiG have both appraised Kadcyla and Perjeta, granted coverage and found these to offer an added benefit compared to existing standard of care, thus securing it a negotiated premium over comparator therapies. **CONCLUSIONS:** Obligatory cost-utility bodies assess cost-effectiveness based on the manufacturer's price, which is often deemed not cost-effective, resulting in frequent delays and denials to access of innovative products. However, if cost-utility bodies instead confidentially evaluated the QALY benefit and determined the proposed price based on this they could achieve potentially much better coverage without compromising their cost-utility principles.

PHP119

TRENDS IN BUDGET IMPACT ANALYSIS ACROSS CENTRAL ASIAN COUNTRIES

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OBJECTIVES: Almost every Central Asian (CA) country, regulatory and reimbursement authorities increasingly require pharmacoeconomic evaluation, as part of a formulary listing or reimbursement submission. A budget impact analysis (BIA) estimates fiscal consequences of adopting a new health technology or intervention within a specific health context. Rapid benefit assessment (RBA) as a basis for central price regulation planned to introduce for new drugs in Kazakhstan. The objective was to investigate the converging trends in the BIA requirements in the CA countries and to compare them with the situation in Kazakhstan. **METHODS:** We conducted a survey of requirements for the pricing and reimbursement process of pharmaceuticals in 5 countries (Kazakhstan, Tajikistan, Kyrgyzstan, Uzbekistan, Turkmenistan). Where needed informal stakeholder interviews were used to supplement lacking information. **RESULTS:** Increasing accessibility and affordability of healthcare services have been considered as important policy objectives in Kazakhstan. In the recent years, because a vast national drug formulary and state benefit outpatient drug program, there are problems with drug provision, cost of medical expenditure is rapidly growing and becoming increasingly unaffordable. Opportunities in all CA countries result from increasing affluence and life expectancy and the diseases associated with these. Some challenges to market access are: poor IP protection, protectionist measures, compulsory licensing, drive to use generics or biosimilars, often produced locally, price controls, variable health insurance/NHS coverage, and limited budgets for prescription drugs. Although demand for new drugs is increasing in these markets, protectionism measures, competition from generics and budget constraints due to the increased burden and requirement for new high priced drugs present a challenge when accessing the pharmaceutical market in CA countries. **CONCLUSIONS:** All of the investigated countries request no BIA from a payers perspective the drugs impact on the change in medical resource consumption is analyzed as part of the pharmacoeconomic and comparative effectiveness analyses.

HEALTH CARE USE & POLICY STUDIES – Health Care Research & Education

PHP120

GENDER DIFFERENCES IN THE USE OF COMPLEMENTARY AND ALTERNATIVE MEDICINE AMONG ADULTS WITH MULTIPLE CHRONIC CONDITIONS

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OBJECTIVES: To examine the association between gender and CAM use among adults with multiple chronic conditions (MCC). **METHODS:** This study used a cross-sectional design with data from 2012 National Health Interview Survey. CAM use was measured using 18 variables. Type of CAM use consisted of alternative medical systems, mind-body therapy, and manipulative-body-based therapy. The relationships between gender and CAM use and types of CAM use were assessed with chi-square tests and logistic and multinomial logistic regressions. Separate logistic regression and multinomial logistic regressions among women and men were performed to assess the factors that are associated with CAM use in each group. **RESULTS:** Overall, 51.5% women and 44.3% men reported ever using CAM; in the past 12 months, 27.6% women and 18.9% men used CAM. Across all types of CAM, higher percentages of women than men used CAM. After controlling for demographic, socio-economic, health and lifestyle factors, women were more likely to report ever using CAM (AOR=1.49; 95% CI [1.35, 1.65]) compared to men. Separate multinomial regressions of CAM use in the past 12 months revealed that the factors associated with CAM use were different for men and women. Women with both physical and mental health conditions were more likely to use CAM in the past 12 months (AOR=1.38; 95% CI [1.17, 1.64]) compared to those with only physical conditions; but no such relationship was found in men. The relationship between age and type of CAM use was significant for women and not for men. **CONCLUSIONS:** Among individuals with MCC, women were more likely to